Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS4598NTC	A. BUILDING _____ B. WING _____	03/02/2009

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CENTER FOR BEHAVIORAL HEALTH LV -CHEYENNE	3470 WEST CHEYENNE AVE, SUITE 400 N LAS VEGAS, NV 89032

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N 00	INITIAL COMMENTS This Statement of Deficiencies was generated as the result of a State Licensure survey and Complaint Investigation conducted at your facility from 2/13/09 to 3/2/09. The State Licensure survey was conducted in accordance with Chapter 449, Facilities for Treatment with Narcotics; Medication Units, effective April 15, 1998. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. Complaint #NV00020945 was unsubstantiated due to lack of evidence.	N 00		
N169 SS=I	449.1548(4) OPERATIONAL REQUIREMENTS In addition to all other requirements set forth in NAC 449.154 to 449.15485, inclusive, each facility for treatment with narcotics and each medication unit shall: 4. Be in full compliance with all applicable provisions of 42 C.F.R. Part 8, all other applicable federal laws and regulations and all other requirements of the SAMHSA and the DEA. This Regulation is not met as evidenced by: 42 Code of Federal Regulations	N169		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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N169	Continued From page 1 8.12 Federal opioid treatment standards (2) Treatment program decisions on dispensing opioid treatment medications to patients for unsupervised use beyond that set forth in paragraph (i)(1) of this section, shall be determined by the medical director. In determining which patients may be permitted unsupervised use, the medical director shall consider the following take-home criteria in determining whether a patient is responsible in handling opioid drugs for unsupervised use. (i) Absence of recent abuse of drugs (opioid or nonnarcotic), including alcohol; (ii) Regularity of clinic attendance; (iii) Absence of serious behavioral problems at the clinic; (iv) Absence of known recent criminal activity, e.g., drug dealing; (v) Stability of the patient's home environment and social relationships; (vi) Length of time in comprehensive maintenance treatment; (vii) Assurance that take-home medication can be safely stored within the patient's home; and (viii) Whether the rehabilitative benefit the patient derived from decreasing the frequency of clinic attendance outweighs the potential risks of diversion. (3) Such determinations and the basis for such determinations consistent with the criteria outlined in paragraph (i)(2) of this section shall be documented in the patient's medical record. If it is determined that a patient is responsible in handling opioid drugs, the following restrictions apply: (e) Patient admission criteria. (1) Maintenance treatment. An OTP shall maintain current procedures designed to ensure that patients are admitted to maintenance treatment by qualified personnel who have determined, using accepted	N169		

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N169	Continued From page 2 medical criteria such as those listed in the Diagnostic and Statistical Manual for Mental Disorders (DSM-IV), that the person is currently addicted to an opioid drug, and that the person became addicted at least 1 year before admission for treatment. (2) Initial medical examination services. OTPs shall require each patient to undergo a complete, fully documented physical evaluation by a program physician or a primary care physician, or an authorized healthcare professional under the supervision of a program physician, before admission to the OTP. The full medical examination, including the results of serology and other tests, must be completed within 14 days following admission. (3) Special services for pregnant patients. OTPs must maintain current policies and procedures that reflect the special needs of patients who are pregnant. Prenatal care and other gender specific services or pregnant patients must be provided either by the OTP or by referral to appropriate healthcare providers. (4) Initial and periodic assessment services. Each patient accepted for treatment at an OTP shall be assessed initially and periodically by qualified personnel to determine the most appropriate combination of services and treatment. The initial assessment must include preparation of a treatment plan that includes the patient's short-term goals and the tasks the patient must perform to complete the short-term goals; the patient's requirements for education, vocational rehabilitation, and employment; and the medical, psychosocial, economic, legal, or other supportive services that a patient needs. The treatment plan also must identify the frequency with which these services are to be provided. The plan must be reviewed and updated to reflect that patient's personal history, his or her current	N169		

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N169	Continued From page 3 needs for medical, social, and psychological services, and his or her current needs for education, vocational rehabilitation, and employment services. (g) Recordkeeping and patient confidentiality. (1) OTPs shall establish and maintain a recordkeeping system that is adequate to document and monitor patient care. This system is required to comply with all Federal and State reporting requirements relevant to opioid drugs approved for use in treatment of opioid addiction. All records are required to be kept confidential in accordance with all applicable Federal and State requirements. (6) Drug abuse testing services. OTPs must provide adequate testing or analysis for drugs of abuse, including at least eight random drug abuse tests per year, per patient in maintenance treatment, in accordance with generally accepted clinical practice. For patients in short-term detoxification treatment, the OTP shall perform at least one initial drug abuse test. For patients receiving long-term detoxification treatment, the program shall perform initial and monthly random tests on each patient. Based on record review and interviews from 2/13/09 to 3/2/09, the facility was not in compliance with 42 Code of Federal Regulations (CFR), Part 8 by not maintaining accurate methadone "take-home" justifications for 3 of 20 clients. The facility did not ensure that the program physician evaluated and admitted 11 of 20 clients to the methadone maintenance program. The facility did not ensure treatment plans were shared with 5 of 20 clients or that assessments were accurate for 1 of 20 clients. The facility did not provide evidence the urine of 1	N169		

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N169	Continued From page 4 of 20 clients was tested for controlled substances on admission. The facility did not follow its pregnant client policy for 3 of 3 pregnant clients and did not ensure documentation was complete for 3 of 3 pregnant clients. Findings include: An email notice written by the State Opioid Treatment Authority (SOTA) was sent to all of the methadone clinics on 12/31/08 regarding the federal requirement that clinic physicians were to admit clients, not nursing personnel, before methadone was dispensed and that standing orders were not to be used. A policy titled, "Responsibility of the Medical Director" indicated a responsibility of the medical director was initial physical examinations. A policy titled, "Criteria for Admission, Re-Admission and Transfer" indicated the medical director makes the final decision on clinic admission. During staff interviews, staff persons reported the clinic physician came to the facility only on Thursdays. The staff persons all reported that if a client came to the clinic when the physician was not present, the client would be examined, evaluated and admitted by nursing staff and would receive methadone daily via standing orders. The clinic physician would then see the client the following Thursday which could be up to seven to eight days after admission. In addition, a staff member reported the clinic physician would also "sign off" on medical physicals performed by the nursing staff and would sign verbal/standing orders on Thursdays even though the physician had not seen the clients.	N169		

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N169	Continued From page 5 A policy titled, "Women and Pregnancy Services" indicated a pregnancy packet be prepared for pregnant clients to track when consents were signed, when contact was made with the client's OB/GYN and to track any other medical or counseling events. The policy also indicated that pregnant clients and other various facility staff were to sign a form titled "Prenatal Care Recommendations." The policy revealed the facility was to obtain an updated medical history regardless of the last medical history obtained in the intake process, schedule a medical appointment and a specialized treatment team meeting. The policy further revealed that three releases were to be obtained regarding communication with the client's OB/GYN and the hospital the baby would be delivered at. Client #1 - The client's current take home justification form indicated the client was at Level 3. A counseling note dated 1/23/09 revealed the client attempted suicide by taking seven take home doses of methadone. The note also indicated the client was reduced to Level 1 as a result of the suicide attempt, but an updated justification form was not located in the client's file for the level decrease. The client's file revealed the client was admitted to the program by a registered nurse (RN) on 11/18/08 (Tuesday). The file contained a general medical history and physical (H&P) completed by the RN on 11/18/08. The H&P was signed by the RN and the clinic physician on 11/18/08, but the file did not contain any other documentation that the clinic physician had personally assessed the client on that date. The medical notes did not contain an entry written by the physician on 11/18/08.	N169		

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N169	Continued From page 6 Client #2 - The client's file contained a treatment plan dated 1/22/09. The treatment plan was signed by the counselor, but not the client. There was no other evidence in the file that the treatment plan had been shared with the client. The file contained evidence that the client visited with the counselor two weeks later on 2/4/09, but the counselor failed to have the client sign the 1/22/09 treatment plan at that time. Client #3 - The client's file revealed the client was admitted to the program by an RN via pre-printed standing orders on 11/25/08 (Tuesday). The file contained a general medical H&P completed by the RN on 11/25/08. The H&P was signed by the RN and the clinic physician on 11/25/08, but the file did not contain any other documentation that the clinic physician had personally assessed the client on that date. The medical notes did not contain an entry written by the physician on 11/25/08. Client #4 - The client's file take home justification form dated 1/14/08 indicated the client was at a Level 5, but on 6/3/08 the client was decreased to a Level 4. There was no updated justification form for the decrease in levels. Client #5 - The client's file revealed the client was admitted to the program by an RN via pre-printed standing orders on 1/5/09 (Monday). The file contained a general medical H&P completed by the RN on 1/5/09. The H&P was signed by the RN and the clinic physician on 1/5/09, but the file did not contain any other documentation that the clinic physician had personally assessed the client on that date. The file contained evidence in the medical notes that the clinic physician assessed the client on 1/6/09; one day after admission.	N169		

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N169	Continued From page 7 Client #6 - The client's file revealed the client was admitted to the program by an RN via pre-printed standing orders on 9/8/08 (Monday). The file contained a general medical H&P completed by the RN on 9/8/08. The H&P was signed by the RN and the clinic physician on 9/8/08, but the file did not contain any other documentation that the clinic physician had personally assessed the client on that date. The file contained evidence in the medical notes that the clinic physician assessed the client on 9/11/08; three days after admission. Documentation located in the client's file indicated she was pregnant. A Pregnancy Protocol packet found in the client's file was reviewed. The packet was initiated on 12/19/08. The packet contained a "Pregnancy Progression Tracker - Nursing" that was blank. The tracker was to contain the following information and dates: documented pregnancy test result date, progression of pregnancy information, prenatal care recommendations form signed by all parties, prenatal treatment contract signed by all parties, signed release dates, medical assessment dates by clinic physician, OB/GYN appointment dates, and treatment team meeting dates. The medical notes indicated the clinic physician had not seen the client until 1/22/09; one month after the clinic was notified the client was pregnant. Client #7 - The client's file revealed the client was admitted to the program by a licensed practical nurse (LPN) via pre-printed standing orders on 5/5/08 (Thursday). The file contained a general medical H&P completed by the RN on 5/5/08. The H&P was signed by the RN and the clinic physician on 5/5/08, but the file did not	N169		

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N169	Continued From page 8 contain any other documentation that the clinic physician had personally assessed the client on that date. The medical notes did not contain an entry written by the physician on 5/5/08. There was no evidence in the file that the clinic physician has seen the client since admission. The client's file did not contain evidence or the results of a urine specimen obtained at admission on 5/5/08. Client #9 - The client's file contained a treatment plan dated 2/6/09. The treatment plan was signed by the counselor, but not the client. There was no other evidence in the file that the treatment plan had been shared with the client. Client #11 - The client's file contained a treatment plan dated 1/9/09. The treatment plan was signed by the counselor, but not the client. There was no other evidence in the file that the treatment plan had been shared with the client. Documentation located in the client's file indicated she was pregnant when she transferred to the facility on 1/8/09. A Pregnancy Protocol packet found in the client's file was reviewed. The packet was initiated on 1/9/09 and was partially blank. The first page documenting the OB/GYN's name and the client's current methadone dose was blank. The coordination of care letter was blank. The consent for release of confidential information was partially completed. The Pregnancy Progression Tracker - Nursing was blank. The prenatal treatment contract was not signed by the nurse or the medical director. The prenatal care recommendations were not signed by the program director, the clinical director nor the medical director. The agreement to voluntarily withdrawal from methadone during	N169		

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N169	Continued From page 9 pregnancy was not signed by the client. Client #12 - The client's file revealed the client was admitted to the program by an LPN via pre-printed standing orders on 9/25/08 (Thursday). The file contained a general medical H&P completed by the RN on 9/25/08. The H&P was signed by the RN and the clinic physician on 10/7/08. The file contained evidence in the medical notes that the clinic physician assessed the client on 10/2/08; seven days after admission. Client #13 - The client's file revealed the client was admitted to the program by an LPN on 11/13/08 (Thursday). The file contained a general medical H&P completed by the LPN on 11/13/08. The H&P was signed by the LPN and the clinic physician on 11/13/08, but the file did not contain any other documentation that the clinic physician had personally assessed the client on that date. The file contained evidence in the medical notes that the clinic physician assessed the client on 1/8/09; two months after admission. Client #14 - The client's file revealed the client was admitted to the program by an LPN via pre-printed standing orders on 7/18/08 (Friday) and re-admitted by an RN on 9/29/08. The file contained a general medical H&P completed by the RN on 7/18/08. The H&P was signed by the RN and the clinic physician on 7/18/08, but the file did not contain any other documentation that the clinic physician had personally assessed the client on that date. The medical notes did not contain an entry written by the physician on 7/18/08. The client's file revealed multiple references to the client's history of being bi-polar, but the	N169		

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N169	Continued From page 10 client's bio-psychosocial assessment indicated the client had no co-occurring disorders. Documentation dated 12/8/08 was located in the client's file indicating she was pregnant. A Pregnancy Protocol packet found in the client's file was reviewed. The packet was initiated on 1/6/09. The first page documenting the OB/GYN's name and the client's current methadone dose was partially completed. The coordination of care letter was blank. The packet contained information that the client was seen by her OB/GYN, but the results of that visit were not in the client's file. The packet did not contain a "Pregnancy Progression Tracker - Nursing" which was found in other pregnant client files. The tracker was to contain the following information and dates: documented pregnancy test result date, progression of pregnancy information, prenatal care recommendations form signed by all parties, prenatal treatment contract signed by all parties, signed release dates, medical assessment dates by clinic physician, OB/GYN appointment dates, and treatment team meeting dates. The client was interviewed during the survey and reported she had been receiving methadone in the facility for about a year and a half, but had never seen the clinic physician. She further reported that the facility knew she was pregnant and was concerned that the clinic physician had not seen her yet. Client #15 - The client's file revealed the client was admitted to the program by an RN via pre-printed standing orders on 8/5/08 (Tuesday). The file contained a general medical H&P completed by the RN on 8/5/08. The H&P was signed by the RN and the clinic physician on 8/5/08, but the file did not contain any other documentation that the clinic physician had	N169		

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N169	Continued From page 11 personally assessed the client on that date. The file contained evidence in the medical notes that the clinic physician assessed the client on 8/13/08; eight days after admission. Client #16 - The client's file revealed the client was admitted to the program by an RN via pre-printed standing orders on 11/25/08 (Tuesday). The file contained a general medical H&P completed by the RN on 11/25/08. The H&P was signed by the RN and the clinic physician on 11/25/08, but the file did not contain any other documentation that the clinic physician had personally assessed the client on that date. The file contained evidence in the medical notes that the clinic physician assessed the client on 12/2/08; seven days after admission. Client #17 - The client's file revealed the client was re-admitted to the program by an LPN via pre-printed standing orders on 10/1/08 (Wednesday), but the file did not contain any other documentation that the clinic physician had personally assessed the client on that date. The file contained evidence in the medical notes that the clinic physician assessed the client on 1/8/09; two months after admission. The client's file contained a treatment plan that was not signed by the client. There was no other evidence in the file that the treatment plan had been shared with the client. Client #18 - The take home justification form located in the client's file indicated the client was at Level 4. The medical notes dated 6/2/08 indicated the client was a Level 5, but there was not an updated justification form allowing for the level increase.	N169		

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N169	Continued From page 12 Severity: 3 Scope: 3	N169		
N174 SS=F	449.1548(9) OPERATIONAL REQUIREMENTS In addition to all other requirements set forth in NAC 449.154 to 449.15485, inclusive, each facility for treatment with narcotics and each medication unit shall: 9. Develop and maintain a system to ensure that prospective and existing clients are not receiving narcotics from any other facility for treatment with narcotics or any other medication unit. This Regulation is not met as evidenced by: Based on record review on 2/13/09, the center did not follow a system to ensure that 13 of 13 prospective clients admitted since August of 2008 were not receiving narcotics from any other narcotic treatment center. Findings include: The form "Consent To Disclose Information Regarding Multiple Registration" was reviewed for Client #1, #3, #5, #6, #10, #11, #12, #13, #14, #15, #16, and #17. The form listed the licensed narcotic treatment facilities in the local area including the facility being surveyed. There was no evidence on the form that anyone from the facility had called any of the facilities on that list to verify if prospective clients were receiving treatment. Client #2's file did not contain the form. The administrative assistant sitting at the front desk was identified as the individual responsible for calling the other treatment facilities to verify if prospective clients were receiving treatment in other facilities. The assistant reported that when a client was admitted, she called the other	N174		

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	NVS4598NTC	A. BUILDING _____ B. WING _____	03/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER FOR BEHAVIORAL HEALTH LV -CHEYENNE	3470 WEST CHEYENNE AVE, SUITE 400 N LAS VEGAS, NV 89032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N174	Continued From page 13 facilities or the counselors would call. The assistant stated she did not mark on the form that she had called the other facilities. The Program Director reported the administrative assistant was new and did not know she was supposed to document on the form after she made contact with the other treatment facilities. Severity: 2 Scope: 3	N174		